Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:		MFDR Tracking #:	M4-10-1197-01
	ALLIED MEDICAL CENTERS PO BOX 24809 HOUSTON TX 77029	DWC Claim #:	
		Injured Employee:	
Respondent Name and Box #:		Date of Injury:	
	ACE AMERICAN INSURANCE CO BOX #: 15	Employer Name:	
		Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Statement states in part, "The date of service January 9, 2009, was denied for 'Payer deems the information submitted does not support the level of service'. As stated in the request for reconsideration the codes we are billing are correct and have concluded that they best suit the service provided…."

Principle Documentation:

1. DWC060
2. Initial medical bills and corrected medical bills
3. EOB
4. Total Amount Sought $95.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

The Respondent did not respond to the DWC060 Request.

Principle Documentation:

1. None

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service and CPT code	Amount in Dispute	Amount Due
1-9-2009	150, 850-203, 97, 593, 850-107 and W1	99213-25- Office visit of an established patient	$80.00	$15.00
		99080-73-Return to Work Form	$15.00	
Total Due:				$15.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution (MFDR) received the DWC060 on October 22, 2009. The date of service in dispute is 1/9/2009. The dispute was filed timely and eligible for review.
2. Audit EOBs for CPT codes 99214-25 and 99080-73 for the following reasons;
   - 150-Payer deems the information submitted does not support this level of service.
   - 850-203 CV: The level of E&M code submitted is not supported by documentation $0.00
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 593-Payment for this service is always subsumed or bundled into payment for another service, no separate payment is made.
   - W1-Workers Compensation state fee schedule adjustment
   - 850-107-CV: Initial allowance recommended in accordance with the state fee schedule guidelines. $120.00
   - CV: Bill and medical records reviewed, service is best described by code 99212. The submitted documentation did not meet the key component requirements for billing a level 99214 lacking a detailed history, exam and/or moderate complexity decision making.

3. Review of the CMS-1500s submitted by the Requestor indicates the health care provider billed CPT codes 99214-25 and 99080-73 on 1/20/2009. Review of the CMS-1500 documents that a corrected bill was sent to the insurance carrier changing the CPT code 99214-25 to 99213-25.
4. Review of the document titled "Request for Reconsideration", dated 2/24/09 states in part, "…I have received EOBs from your company on the above-mentioned patient for service rendered on 1-9-09. Payment denied for the following reason: CAC-16 Payer deems the information submitted does not support the level of service. After careful analysis, we have decided to down-code the service to 99213. We believe that this code better suits the service provided; therefore, we request a review of charges and reimbursement to our facility for the appropriate charges…."
5. No audit EOBs were submitted with the DWC060 request for the down coded CPT code 99213-25, however, as indicated by the Requestor in their Request for Reconsideration, the carrier denied the charge 99213-25 with denial reason code CAC-16.
6. CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family."
7. The documentation submitted by the Requestor did not sufficiently support the level of service billed.
8. Copy of the CMS-1500 containing CPT code 99213-25 and 99080-73 indicates "Corrected Claim". The preamble to Rule 133.250(d)(1) indicates that reconsideration may include corrections relating to modifiers and/or number of units, Rule 133.250(d)(1) indicates that requests for reconsideration of a bill shall reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill. Because the HCP submitted a bill with a new CPT code, it was considered a new bill, not a request for reconsideration. Thus, the new bill was subject to the 95-day deadline.
9. §408.027 requires providers to submit claims for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. No sufficient documentation was submitted by the Requestor to support that the corrected CPT code 99213-25 was filed with the carrier no later than 95 days after the date of service and no sufficient documentation was submitted to support that the Requestor made a request for reconsideration of the corrected claim as required under Rule 133.250. As a result, no reimbursement is recommended for CPT code 99213-25.
10. Review of the DWC-73 dated 1/9/2009 contains the required information set out under Rule 129.5. As a result and in accordance with Rule 129.5 (i) the Requestor is entitled to reimbursement in the amount of $15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Section 133.307, 134.203, 129.5, 133.250

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §§413.031 and 413.019, the Division has determined that the Requestor is entitled to $15.00 reimbursement.

		April 22, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.